

# FEDERALISM FROM FEDERAL STATUTES: HEALTH REFORM, MEDICAID, AND THE OLD-FASHIONED FEDERALISTS' GAMBLE

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How can the states retain relevance in an era of federal statutory law? The persistence of the states and our enduring attachment to “federalism” in an increasingly national and global regulatory environment has occupied the minds of many scholars.<sup>1</sup> For the most part, however, the U.S. Supreme Court, because of its role as the final expositor of constitutional meaning, has been viewed as the primary arbiter of what federalism is and what is required to protect it. Less often explored has been *Congress’s* role in giving meaning to federalism in the modern administrative state.<sup>2</sup> Specifically, the possibility to which this Essay wishes to draw attention is that federal *statutes* may now be the primary way in which state power is created and protected. To be clear, the claim is not about federal statutes that are modest in ambition and leave most areas exclusively to state regulation. Rather, the claim is about major federal statutes that, even as they extend federal power, entrust to the states much of their implementation and elaboration.

The 2010 health reform legislation—The Patient Protection and Affordable Care Act<sup>3</sup> (ACA)—is the most prominent recent example of

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1. For a well-known example of one such treatment, see Larry Kramer, *Putting the Politics Back into the Political Safeguards of Federalism*, 100 COLUM. L. REV. 215, 227, 234 (2000) (arguing that the political-party system has given the states an enduring voice on the national level).

2. As shall be evident, my point is different from the famous “political safeguards” argument. See Herbert Wechsler, *The Political Safeguards of Federalism: The Role of the States in the Composition and Selection of the National Government*, 54 COLUM. L. REV. 543 (1954) (arguing that state representation in Congress and the nature of the political process work to protect state autonomy). I assume that national action is the “ordinary,” not the “special,” case and am interested in how such national action itself might generate and protect the benefits and values that are more typically associated with autonomy-focused theories of federalism.

3. Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

such a statute. And the Supreme Court's 2012 decision about the constitutionality of that statute revealed that the Court emphatically disagrees with this Essay's claim.<sup>4</sup> But federalism proponents may be doing their own cause a disservice with their reluctance to see federalism in federal statutes.

Congress seems to have taken a different view. Since the New Deal, Congress has repeatedly invited the states to be the front-line implementers of its new federal laws—federal-statutory design decisions that are often described by legislators as respectful of “federalism,” even as the new national legislation displaces traditional state dominance over a particular area of policy. Health reform, for example, invited the states to serve as central policy-makers and implementers in key areas of the statute, including its expansion of Medicaid and its establishment of insurance exchanges (the law's new “one stop shopping” portals for insurance purchase).<sup>5</sup>

The Court, however, as well as some other self-identified state-power proponents, appears to believe that state power is undermined, not advanced, when Congress invites states into federal statutes in this manner. But from a federalism-protective perspective, the Court's position may well have the reverse of its intended effect. Insisting on separation is unlikely to stop Congress from legislating altogether. At most, it will encourage Congress to legislate without state partners—a course of action that is likely to increase, not decrease, national power.

The issue that brought these matters to the fore in health reform was the ACA's proposed Medicaid expansion. Medicaid is a half-century-old federal program that is jointly administered by states and the federal government, and has been incrementally expanded since its inception. Medicaid's paradigmatic “cooperative federalism” and its slow course of development are the direct result of policymakers' continued efforts to bring the federal government into an arena dominated by the states while still respecting “federalism.” But, in the health reform litigation, the Court held that Congress's most recent expansion of Medicaid went too far and in the process implied that Congress loses some power over how it may expand federal programs once it invites states to participate.<sup>6</sup> In the name of federalism, seven Justices held that states were effectively free to reject the amendments to the Medicaid statute that Congress had passed and the President had signed.

The Court's opinion, however, relied on a vision of federalism that has been on the decline at least since the New Deal. The Court insisted that federalism and its benefits—including local control and the ability of states

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4. *Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB)*, 132 S. Ct. 2566 (2012).

5. Patient Protection and Affordable Care Act § 2201.

6. *NFIB*, 132 S. Ct. at 2606–07 (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.) (finding the Medicaid expansion unconstitutional); *id.* at 2666–67 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting) (joining the part of the Roberts opinion finding the Medicaid expansion unconstitutional).

to check federal power—are best effectuated by state separation from federal law rather than state participation in it. That vision depends on what no longer exists: significant areas of regulation that are reserved to the states and into which federal lawmaking may not tread. Today, the states' relevance on the national policymaking level comes mostly from *Congress's discretion*, not from the states' exclusive control over policy as a matter of (judicially monopolized) boundary-emphasizing constitutional law. Congress may design federal statutes that retain central roles for states or Congress may design federal statutes that displace the state function entirely.

Health reform typifies this modern state of affairs. In designing the statute, Congress followed its typical legislative path—one of incremental federal lawmaking over a historical backdrop of state control—a path that, as in the case of numerous social programs enacted over the past century, produced a new federal statute that took some power from the states with one hand but gave the states new (federal-law-granted) powers with the other. The Court interpreted these moves as fundamentally antifederalist. But would federalism really have been better served had Congress pushed the states to the periphery?

Since the decision, moreover, some state-power proponents have taken similar positions to the Court's with respect to other aspects of the statute. Specifically, the majority of Republican-controlled states have rejected Congress's offer to let the states, rather than the federal government, run the Act's new health insurance exchanges.<sup>7</sup> Their effort, like the Court's, is to fight a battle already lost; that is, to try to derail the progress of this federal lawmaking altogether. But the Court *upheld* the constitutionality of the rest of the health reform statute, including the exchange provisions. The states' decision not to participate thus opens the door to a wholesale federal takeover of health insurance regulation in those same states that opposed the federal law in the first place. What's more, that opening may pave the way for additional federal encroachment that might not otherwise occur if states implemented the Act themselves.

The gamble is a big one. Unlike the contest over Congress's power to enact an insurance-purchase mandate—which received far more public attention but is unlikely to arise again<sup>8</sup>—this federalism question is certain to recur. Most major federal programs in this country rely at least in part on the kind of state-led implementation that the Court's opinion attempted to

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7. Since the Court held in *Printz v. United States* that Congress cannot commandeer state executive authority, Congress has given the states the choice to administer new federal programs or to opt out. 521 U.S. 898, 935 (1997). In the health reform statute, Congress articulated a default-preference for state implementation of the exchanges but provided that the federal government would run the exchanges for the states if the states opted out or were unprepared to implement by the 2014 deadline.

8. The question whether Congress has authority under the Commerce Clause to require individuals to purchase health insurance is unlikely to arise again because such purchase-mandates are rarely necessary and, in any event, Congress now knows to use a different power (such as its taxing power) to effectuate the same result.

deter. The Court's opinion already has injected significant uncertainty into these cooperative federalism schemes and may result in Congress using less of them in the future.

This is not to say that Congress's efforts to include the states always effectuate federalist, as opposed to nationalist, goals, or that it is easy to tell which federal-statutory moves are state protective. Different states might take divergent views of different statutes and, of course, not everyone will agree that state-protective policy solutions are normatively ideal for every policy problem. Nor is it to say that Congress must not do a better job in making clear how much power it intends to delegate to the states relative to federal agencies or other implementers when it offers them roles in federal administration. The point, rather, is that these federal-statutory-implementation relationships are the critical federalism relationships of the statutory era. The real work to be done is not in eliminating these partnerships altogether, but in recognizing Congress's centrality in creating them and the need for legal rules to govern their successful operation.

## I. THE STAKES FOR HEALTH POLICY AND FOR CONSTITUTIONAL LAW

Health reform offered both Congress and the Supreme Court the opportunity to address the modern conundrum of the states' place in a legal world dominated by federal statutes. Congress did so as a matter of health policy; the Court did so as a matter of constitutional law. Neither did so with particular clarity.

### *A. Health Policy*

Federalism has been the subject of robust debate in the health policy context for decades. The question in the policy context has typically been framed as a functional one; that is, which level of government, state or federal, is best situated to oversee health care regulation and finance? Proponents of state regulation have emphasized the benefits of local variation and the expertise of local health administrators in arguing for state control. On the other side, nationalists emphasize that local regulation does not work given the countercyclical nature of programs like Medicaid: expenses for assistance programs increase during difficult economic times when governments (especially states with balanced-budget requirements) have less revenue to cover them. Nationalists also argue that state-level health reform is impossible given the national market for health care: providers and insurers will simply leave aggressive states if other states have fewer restrictions.<sup>9</sup>

Congress essentially punted the answer to this health-policy question when it enacted the ACA. As detailed below, the statute is a paradigm of the kind of structural schizophrenia that results from incremental federal

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9. For examples from this robust literature, see *FEDERALISM AND HEALTH POLICY* (John Holahan et al. eds., 2003), and *HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES* (Robert F. Rich & William D. White eds., 1996).

lawmaking—over terrain historically controlled by the states—by a Congress sensitive to undercutting federalism. The ACA offers few answers to the functional question of where health administration ideally should be located. Instead, as detailed below, the statute not only increases federal authority, but also gives authority to the state and federal governments acting together and leaves some authority in state hands alone, as well as in the hands of private actors.

Of course, depending on the policy question at hand, such a varied structural approach is not always undesirable. In the context of health reform, however, the pre-ACA landscape of regulatory structural fragmentation had been much lamented,<sup>10</sup> and Congress disappointed the many health policy experts who had hoped that the ACA would address the field's structural issues head-on. Congress did not, for example, address why, as a matter of good policy, the nation's health insurance program for the elderly (Medicare) is run by the federal government, while the nation's health insurance program for the poor (Medicaid) is run jointly with the states. Instead, the structure of the ACA (which extended both programs) was the product of what might be called authority-allocating, federalism-inspired path dependence: Congress gave the states a lead role in the new federal statute in those same areas in which states had previously exerted primary authority, namely, Medicaid and insurance regulation.

### *B. Law*

On the legal side, this question of the modern state-federal relationship has been framed differently, as one of constitutional structure; namely, whether the Constitution's protections of state sovereignty limit the way in which the federal government uses (or does not use) the states to administer or implement federal legislation. But the more provocative way to ask the same question is to ask what the continuing relevance is *at all* of legal doctrines that protect "federalism" in an era in which our most important laws come from federal legislation that Congress has the power to enact without any role for the states in the first place.

"Constitutional" federalism is typically a federalism defined by the allocation of powers in our founding document and one that has been understood by many to prescribe separate spheres of state and federal responsibility and to have as its goal the preservation of state autonomy. But, as many scholars have noted, that brand of federalism is increasingly irrelevant. The New Deal brought the federal government squarely into most areas of traditional state regulation, including the world of social policy, and today, if statutes are crafted properly, there are few areas into which the federal government may not go. As such, the apposite question is not how federalism should protect what are now mostly nonexistent areas of

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10. See THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS (Einer Elhauge ed., 2010).

exclusive state authority.<sup>11</sup> Rather, the apposite question is whether there might be a new type of federalism—which might be called *intrastatutory* federalism—that functions *within* the world of federal statute making. Is there a federalism in which state power comes from federal statutes—from Congress’s decision to design federal laws that rely on state administration—rather than a federalism in which state power derives from its separation from federal law?

In the health reform case, seven Justices refused to acknowledge the possibility of this modern expression of our foundational state-federal relationship. The joint dissent (for Justices Scalia, Kennedy, Thomas, and Alito) expressly disputed the proposition that Congress’s decision to allow “state employees to implement a federal program is more respectful of federalism than using federal workers alone,” and asserted that “[t]his argument reflects a view of federalism that our cases have rejected.”<sup>12</sup> The Chief Justice’s opinion, like the joint dissent, extolled the “independent power of the States . . . as a check on the power of the Federal Government.”<sup>13</sup>

Both opinions read as *homages* to federalism. But the federalism that the Court embraced was federalism in its bygone, separate-spheres form. The structural choice for Congress in health reform was not, as the Court would have it, “federal legislation versus state legislation.” Rather, the structural question was “federal legislation administered by *whom*?”

Congress answered that question in health reform by including the states as front-line partners in the implementation of several parts of the statute, including in its Medicaid expansion. Congress did not need to do this, as all nine Justices acknowledged: the federal government unquestionably had the constitutional power to implement the Medicaid expansion all by itself. But the Court viewed Congress’s attempt to expand Medicaid in its joint state-federal form as an encroachment on federalism. Specifically, Congress conditioned continued state involvement in Medicaid on a state’s acquiescence to Congress’s new amendments to the program. The Court viewed this as a coercive trap that violated state sovereignty: given Medicaid’s centrality in every state, the Court opined, states had little choice but to go along with Congress’s amendments.

I have previously written about the way in which state implementation of national law may, indeed, sometimes be a tool of national encroachment.<sup>14</sup> But one also must consider the alternative, and that is the point of this Essay: in a world of near limitless federal power to spend money for social

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11. For an excellent treatment of the opposite view, see MALCOLM M. FEELEY & EDWARD RUBIN, *FEDERALISM: POLITICAL IDENTITY AND TRAGIC COMPROMISE* (2008) (arguing federalism without autonomy is simply decentralization).

12. *NFIB*, 132 S. Ct. 2642, 2660 (2012) (joint dissent).

13. *Id.* at 2578 (majority opinion).

14. Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534 (2011).

welfare,<sup>15</sup> and given Congress's proven tendency to legislate incrementally (i.e., *through a series of amendments over time*) what good does the Court's opinion do the states, or the cause of federalism? Now that the Court has limited Congress's flexibility to legislate incrementally when it utilizes state partners, perhaps Congress will think twice before including the states at all the next time.

The Court did not acknowledge this possibility, or the possibility that state administration of federal law might sometimes empower, rather than undermine, state players.<sup>16</sup> Instead, the Court may have assumed that erecting barriers to state implementation of federal law would stop Congress from enacting major federal legislation altogether. This is a dubious assumption at best. Every modern president—from President Nixon and the Clean Air Act,<sup>17</sup> to President George W. Bush and No Child Left Behind,<sup>18</sup> to President Obama and the ACA<sup>19</sup>—has passed major federal legislation. The New Deal tide will not so easily be turned back.

## II. INTRASTATUTORY FEDERALISM AS THE FEDERALISM OF THE MODERN ERA

In legal circles, only a handful of commentators have even acknowledged the possibility that federal statutes, in general, might be a source of constitutional interpretation and change.<sup>20</sup> Even among that number, matters of federal statutory design are rarely described as federalism constituting. Still rarer—because it is so antithetical to the state autonomy typically associated with federalism—is a lawyer's understanding of federalism as a relationship that comes by the *grace of Congress*.

But most major policy initiatives since the New Deal seem to embrace this possibility. From the early family and old-age assistance laws, to the

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15. This is because Congress can tax and spend as it wishes for the general welfare, *see* U.S. CONST. art. I, § 8, cl. 1, a power that even the conservative wing of the Court agrees gives Congress enormous authority over social policy. *See, e.g., NFIB*, 132 S. Ct. at 2643 (joint dissent).

16. There is some evidence that this notion of empowerment, though perhaps counter-intuitive to some, may be taking broader hold. Heather Gerken, for example, makes a similar point in a speech written independently at approximately the same time as this Essay. *See* Heather Gerken, *The Federalis(m) Society*, 36 HARV. J. L. & PUB. POL'Y (forthcoming 2013) (on file with author); *see also* Ted Ruger, *Health Policy Devolution and the Institutional Hydraulics of the Affordable Care Act*, in *THE HEALTH CARE CASE* (Persily et al. eds., forthcoming 2013) (predicting that states will use waivers under health reform for leverage).

17. Clean Air Act Amendments of 1970, Pub. L. No. 91-604, 84 Stat. 1676 (codified as amended in 42 U.S.C. §§ 7401–7671 (2006)).

18. No Child Left Behind Act of 2001, Pub. L. No. 107-110, 115 Stat. 1425 (2002) (codified in scattered sections of 20 U.S.C.).

19. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

20. *See* 3 BRUCE ACKERMAN, *WE THE PEOPLE: THE CIVIL RIGHTS REVOLUTION* (forthcoming 2014) (on file with author); WILLIAM N. ESKRIDGE & JOHN FEREJOHN, *A REPUBLIC OF STATUTES: THE NEW AMERICAN CONSTITUTION* (2010); Ernest A. Young, *The Constitution Outside the Constitution*, 117 YALE L.J. 408 (2007).

environmental statutes of the 1970s, to the health reform legislation of 2010, Congress has invoked federalism in giving states the option of serving as primary implementers of the most important federal programs. Moreover, in the same spirit of federalism, Congress often gives states flexibility to do this federal work; for example, by establishing federal floors above which states may innovate or by allowing states to apply for waivers from federal requirements so that they can experiment with ways to accomplish the federal law's goals. In turn, the states have constructed local administrative bureaucracies to implement federal policy and, concomitantly, have become ever more expert in the areas entrusted to their administration. In this fashion, Congress has allowed the states to remain important players in the current policymaking world.<sup>21</sup>

### A. Motivations

There are many good and varied reasons why Congress relies on the states to implement federal law.<sup>22</sup> Some of these reasons are pragmatic: the federal government does not have sufficient personnel to administer its programs, and state administrators often are more expert. Some reasons are functional: certain programs may benefit from regional variation (water policy, for example, may look different in the Northeast and the Southwest); or Congress may wish to incentivize state-level experimentation in federal policy administration to generate data for future national policy decisions.

Other motivations may be instrumental. State administration of new federal programs may make federal legislative expansions more politically palatable for those who prefer (at least the appearance of) "small" government. Running controversial federal programs through the states also may diffuse federal accountability. Sometimes, these moves are "nationalist" in nature: a use of the states to increase federal power in a below-the-radar fashion. Other times (or perhaps simultaneously), they may be an effort to effectuate values that we normally associate with "federalism," even as Congress steps in to regulate. For example, a federal law that relies on state implementation might be a way of expressing a preference for experimentation, local control, or respect for areas of traditional state expertise.

The point is not that Congress's reliance on state administration is always "ideal" from a state-power perspective or that there is a single model to evaluate. Some statutes delegate power equally to all implementing states; others give certain states leadership roles developing national policy.<sup>23</sup>

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21. Cooperative federalism existed before the New Deal too, but it has become ubiquitous since. See Jerry L. Mashaw, *Reluctant Nationalists: Federal Administration and Administrative Law in the Republican Era, 1801–1829*, 116 YALE L.J. 1636, 1649–50 (2007) (describing early cooperative federalism in quarantine laws).

22. For elaboration, see Gluck, *supra* note 14.

23. See, e.g., Clean Air Act, 42 U.S.C. § 7543(e)(2)(A) (2006) (providing California a special authorization to "adopt and enforce" emissions standards).



Some statutes give states much policymaking discretion, while others use states to administer what are essentially uniform national programs. In the ACA alone, we see this type of dizzying variety.<sup>24</sup> The point is that congressional reliance on state implementation is ubiquitous and complex, and that legal doctrine currently offers no tools that assist in evaluating its many forms. The point is also that state implementation, at least some of the time, can offer states a voice in national policymaking.

*B. Is This "Federalism"?*

Some will likely contest that this is "federalism" at all. Protesters may offer "decentralization" as a preferred label,<sup>25</sup> precisely because the state presence comes at Congress's pleasure. But more is going on here than the managerial allocation of responsibility. In fact, it seems unmistakable that federalism norms are being expressed in at least some of these statutes.

Consider, as an example, the question whether to centralize administration of the ACA's newly created insurance exchanges in the federal government or whether to give the states the right of first refusal to exercise control over their administration—a question that was not at issue in the litigation. This exchange governance was the key question that divided the House and Senate versions of the legislation, with the Senate invoking "federalism" values to insist on the state-leadership default preference that ultimately carried the day. But make note: this federalism was to come in the form of state administration of *federal* law—not in the exclusion of the federal government from the field.

And let's be clear. As a matter of existing constitutional doctrine, most people agree that the federal government could implement programs like the environmental statutes or health reform all by itself. In the health reform case, what divided the Court was not whether Congress had the constitutional power to expand access to government-provided health insurance but rather *how* Congress did it.

Perhaps the Court would have reached a different answer had it thought about the question in terms of that choice. Consider again, in this light, the health insurance exchanges. As a result of the triumph of the state-led version of those exchanges, individuals and small businesses in those states that accept Congress's invitation to run the exchanges will continue to purchase health insurance through state-governed channels, a result that, at least on the surface, appears consistent with the traditional presumption (itself legislatively established through Congress's discretion in the McCarran-Ferguson Act of 1945) that health-insurance regulation is an area of state control. As a matter of formal constitutional doctrine, of course, an exchange run by the federal government would be no different: federal law—the ACA—will regulate the exchanges no matter who runs them. But as a matter of how individual Americans will experience this regulation, it

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24. Gluck, *supra* note 14.

25. FEELEY & RUBIN, *supra* note 11, at 20–37 (2008).

will be on the local level. And as a matter of what level of government is setting much of the relevant policy, it is *still the states*, precisely because Congress—even though it didn't have to—built state-implementation flexibility into the statute. The same point can be made about the difference between expanding access to health insurance through Medicaid, which puts states at the forefront, as opposed to through Medicare, which does not.

The Chief Justice himself began his opinion by writing that traditional federalism assures that “the facets of governing that touch on citizens daily lives are normally administered by smaller governments closer to the governed.”<sup>26</sup> The Court seemed too quick, however, to conclude that erecting barriers to state implementation of federal law would serve that goal. Fifteen years earlier, in *Printz v. United States*,<sup>27</sup> another highly contested case about state administration of federal law, the dissenting Justices (including Justice Breyer, who joined the Chief Justice in the ACA's Medicaid ruling) put the question more realistically. “Why, or how,” the dissent asked, “would what the majority sees as a constitutional alternative—the creation of a new federal . . . law bureaucracy, or the expansion of an existing federal bureaucracy—better promote either state sovereignty or individual liberty?”<sup>28</sup> The *Printz* dissenters also might have asked how it would better promote administration of law by those governments closest to the people.

It remains a subject for debate whether the kinds of “everyday” experiences with state administration that the state exchanges and Medicaid will offer are federalism in the “constitutional” sense. But it is not clear that the labels really matter.<sup>29</sup> One can argue that the prevalence of these kinds of arrangements has shaped and changed what federalism means as a matter of “constitutional law,” or one can argue alternatively that, if

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26. *NFIB*, 132 S. Ct. 2566, 2578 (2012).

27. 521 U.S. 898 (1997).

28. *Id.* at 977 (Breyer, J., dissenting joined by Stevens, J.); *see also id.* at 959 (Stevens, J., dissenting joined by Souter, Ginsburg, and Breyer, JJ.) (“By limiting the ability of the Federal Government to enlist state officials in the implementation of its programs, the Court creates incentives for the National Government to aggrandize itself. In the name of State's rights, the majority would have the Federal Government create vast national bureaucracies to implement its policies. This is exactly the sort of thing that the early Federalists promised would not occur, in part as a result of the National Government's ability to rely on the magistracy of the States.”). Cf. Judith Resnik, *Lessons in Federalism from the 1960s Class Action Rule and the 2005 Class Action Fairness Act: “The Political Safeguards” of Aggregate Translocal Actions*, 156 U. PA. L. REV. 1929, 1966 (2008) (arguing that, by including the states, “[a] national response can emerge without turning everything into a ‘federal case.’”).

29. The doctrinal relevance of labeling in this context seems to go to the alterability of the doctrines announced. To the extent that one believes that Congress's federal statutory design decisions are creating new constitutional understandings of federalism, then perhaps future congresses, and even courts, have less power to alter those understandings than they would have to interpret and change statutory understandings. This possibility raises a host of other questions, however—including the presumptive unconstitutionality of congressional efforts to bind the hands of future congresses—that require deeper consideration elsewhere (and which also attach to most theories of statutes-as-constitutional-law, *see supra* note 20, not just the one advanced here).

constitutional federalism is only about federalism in the sense of autonomy, then that brand of federalism is increasingly irrelevant. But the potential irrelevance of constitutional federalism in its narrowest sense does not mean that something often very state centered has not replaced it.

### III. THE ACA'S TAPESTRY OF FEDERALISM

Of course, the reason that the Supreme Court had occasion to address the intrastatutory federalism question at all is because of how the ACA was designed.

#### *A. The ACA's Structural Fragmentation*

For the past century, two overarching questions have dominated the health-policy discourse. The first question is that of the health care system's basic normative framework: whether we should have a system that rests on "personal responsibility" (everyone for him/herself) or, instead, whether a "solidarity" model (one that emphasizes "mutual aid and support") should govern.<sup>30</sup> The second question is the structural one, and asks which level of government, state or federal (or perhaps the private sector), should be responsible for ensuring access to health care for those deemed entitled to receive it.

Congress tackled both questions when it passed the ACA. Or, more accurately, it tried to answer the first and declined to answer the second. The ACA offers the strongest federal legislative position thus far on the personal responsibility-versus-solidarity debate. The statute's primary goal is universal access to health care (i.e., solidarity), which it accomplishes by making health insurance available to as many Americans as possible.<sup>31</sup> The Medicaid expansion at issue in the litigation was one part of that effort, along with other aspects of the statute, including amendments to Medicare, the establishment of the health insurance exchanges, the provision of subsidies for the purchase of insurance, and the imposition of new requirements on insurers to make insurance more accessible. To make the reforms economically viable for insurers, the law expands the pool of insured citizens, requiring almost all individuals to have insurance (or be covered through one of the federal assistance programs), a requirement colloquially referred to as the "individual mandate."<sup>32</sup>

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30. Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L.J. 199, 205, 207 (2008).

31. The statute is not unequivocal on this point. Some provisions, particularly the so-called "wellness provisions" that allow healthy individuals to reduce their insurance costs, reflect a reluctance to leave the personal responsibility model completely behind. See generally Tom Baker, *Health Insurance, Risk and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577 (2011); Jessica L. Roberts, *Health Law As Disability Rights Law*, MINN. L. REV. (forthcoming 2013).

32. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10106(b), 124 Stat. 119, 909-11 (2010) (codified at 26 U.S.C. § 5000A (Supp. V 2011)).

But Congress essentially punted the second, structural, health-policy question. The ACA is a Solomonian and mostly unsatisfying response to the functional question of whether the states or the federal government are best situated to oversee health care, or even to the preliminary question of whether government (any government) should be involved in health care in the first place.

Instead, the ACA offers something for everyone, and does not justify as a functional matter why it divides the world the way it does. The statute includes all of the following government-structure models: a federal-only model in the statute's Medicare reforms; a cooperative-federalism model in the statute's Medicaid expansion and health insurance exchange provisions; a new "hybrid" federalism model, created in the ACA's implementing regulations, that allows states to take the lead but allows the federal government to perform certain tasks that benefit from centralization or economies of scale across groups of states; and a state-only model that expressly leaves certain functions entirely in state hands.<sup>33</sup> The statute also includes a private market model in its reliance on employer-provided, private insurance as the default system. (Indeed, the fact that the statute calls the insurance-purchase mandate a "personal responsibility" requirement is likely no coincidence; the label, and the maintenance of the private insurance system, appear to be nods toward those who would prefer a private-market, antisolidarity model altogether.)

The Court's opinion was essentially a reflection on these two health-policy questions, reframed in legal terms. With respect to the first question, Chief Justice Roberts's opinion and the joint dissent, in discussing both the mandate and the Medicaid expansion, each evinced profound discomfort with Congress's policy preference for the solidarity model, and each repeatedly blanched at the notion of the healthy subsidizing the sick. The link between that normative discomfort and the constitutional-law holdings in the opinions is a fascinating subject, but one beyond the scope of this Essay. The remainder of the Essay focuses on the second, structural question: namely, the ACA's use of intrastatutory federalism and the Court's reaction to it.

### *B. The Link Between Federalism and Federal Policy Incrementalism*

What explains the ACA's structural diversity? It does not appear that any health policy expert has claimed that it was the result of a considered policy decision. Instead, the statute's something-for-everyone approach to the state's role seems to have been the result of politics (getting to the right number of votes) and path dependence. Specifically, the road to the ACA's structural fragmentation was typical of the *incremental* way in which Congress legislates. The Court did not seem to understand this, or at least did not acknowledge it. Nor did the Court recognize that such

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33. For more detail about the fragmented structure of the Act, see generally Gluck, *supra* note 14.

incrementalism tends to favor the development of federal statutes that include central, albeit sometimes fragmented, roles for the states.

### 1. Incrementalism and State Entrenchment

Political scientists have consistently demonstrated that Congress legislates in piecemeal fashion.<sup>34</sup> There are many reasons for the persistence of this policy incrementalism, including the numerous barriers to lawmaking of any sort in Congress and the difficulty of attaining consensus in a polity as diverse as ours. Of particular relevance here, there is also an explicit link between Congress's tendency toward policy incrementalism and the design of federal statutes that rely on state administration. This is largely because what often precedes our incremental federal legislation, especially in the social policy arena, is decades of lawmaking, expertise building, and institution entrenching by the states that previously occupied the field.

The historical backdrop of state social policy regulation creates both political and pragmatic incentives for Congress to rely on, rather than to displace, entrenched state administrative apparatus. As a political matter, the same federalism-like concerns about big government and respect for traditional areas of state authority often are cited to support state administration of federal law. Pragmatically, in addition to the lack of sufficient federal personnel, earlier-established state bureaucracies provide ready experts to implement new federal legislation should the states wish to participate.

The result can be a policy scheme that is structurally fragmented in multiple ways. The new federal program, like the ACA, may have some aspects designed to be implemented by the states and other aspects designed to be implemented by the federal government. Even with respect to those aspects designed to be implemented by the states, states sometimes opt out, in which case the federal government must step in to operate the program in some states but not in others. The new federal program also rarely occupies the entire field, and so substantial regulatory power often remains, as it historically had been, under exclusive state control.

The 1965 legislation that gave birth to Medicare and Medicaid offers a quintessential example of this type of federal policy development.<sup>35</sup> The health-policy backdrop to the Social Security Act of 1965 was essentially a system of limited charity care provided by the states and localities to the "deserving poor." Conservative Republicans and Southern Democrats, both concerned about federal-government aggrandizement, opposed expansion of the federal government into health care. As a result, during the federal legislative process, non-southern Democrats focused on incremental

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34. Charles E. Lindblom, *The Science of "Muddling Through,"* 19 PUB. ADMIN. REV. 79, 84 (1959).

35. See Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in scattered sections of 42 U.S.C.).

expansion, targeting their efforts at a particularly sympathetic population (the elderly) as beneficiaries of the new federal health insurance program.

The resulting compromise has been described as a “three-layer cake,”<sup>36</sup> a metaphor that captures its inclusion of, among other things, both federal- and state-led insurance models. The decision to lodge what became Medicaid in the states was partially the result of the kind of path dependence described above<sup>37</sup>: Even though the new program was a federal program, it was *state* run, and as such was viewed as an extension of prior state charity-care efforts, rather than as a major reform of them.<sup>38</sup> But making Medicaid state administered also was an effort to prevent further federal encroachment: federalism proponents wished to “put a fence around Medicare,”<sup>39</sup> treating that program as an exceptional federal venture into the health care arena and maintaining state control as the norm. This deserves emphasis. Designing a federal law so that it could be implemented by the states was seen as *protective* of federalism. Completing the fragmentation, the statute left large swaths of regulation entirely in state hands, including the regulation of the private insurance industry.<sup>40</sup>

The same story can be told outside the health care arena. Indeed, one is hard-pressed to identify any examples of major social policy legislation in which Congress wiped the slate clean of all preexisting state structures and enacted comprehensive, federal-only reform in a single legislative effort. From the near half-century transformation of the state-administered federal food-stamp program—incremental change that occurred through a series of federally authorized state experiments (“demonstration projects”) and congressional amendments;<sup>41</sup> to the enactment of the Supplemental Security Income Program as an effort to standardize the state-led Old-Age Assistance and Aid to the Blind programs;<sup>42</sup> to the early federal efforts to fund state environmental programs that eventually led to the Clean Air and Clean Water Acts;<sup>43</sup> to the 1935 Social Security Act’s evolution from an

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36. STUART ALTMAN & DAVID SHACTMAN, *POWER, POLITICS, AND UNIVERSAL HEALTH CARE: THE INSIDE STORY OF A CENTURY-LONG BATTLE* 139 (2011).

37. Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 445–47 (2012).

38. *Id.*

39. ALTMAN & SHACTMAN, *supra* note 36, at 141.

40. State control over private insurance essentially continued until the 1974 ERISA statute partially eroded it. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, § 514, 88 Stat. 829, 897 (1974) (codified at 29 U.S.C. § 1144 (2006)).

41. Food Security Act of 1985, Pub. L. No. 99-198, 99 Stat. 1354 (codified as amended in scattered sections of 7, 15, 16, and 21 U.S.C.); Hunger Prevention Act of 1988, Pub. L. No. 100-435, 102 Stat. 1645 (codified as amended in scattered sections of 7 U.S.C.).

42. *NFIB*, 132 S. Ct. 2566, 2639 n.23 (2012) (Ginsburg, J., concurring in part, concurring in judgment in part, and dissenting in part).

43. The first Federal Clean Air Act, enacted in 1963, provided grants to state and local air pollution control districts. Pub. L. No. 88-206, 77 Stat. 392 (1963). The first Federal Clean Water Act of 1948 (also known as the Federal Water Pollution Control Act) was “primarily based on state and local efforts.” *The Clean Water Act: Protecting and Restoring our Nation’s Waters*, EPA, <http://water.epa.gov/action/cleanwater40/cwa101.cfm> (last

effort to replace state old-age pension programs to its expanded form today,<sup>44</sup> this is the common arc of modern federal policy development.

Moreover, there is a cycle here, one in which state-based federal policy incrementalism continues to perpetuate itself. With each new federal program that relies on state implementation, state administrative bureaucracies are further expanded and become more expert. This, in turn, makes their continuing utilization by the federal government more likely.

The ACA is no exception. Despite the Court's emphasis on the statute's length and scope, the ACA's main components are drawn from preexisting programs (which themselves were the product of an incremental legislative approach). The ACA expands Medicare, Medicaid, and the private insurance system, rather than putting in place the kind of more coherent structure one would expect (and many had hoped for) had Congress been drafting from scratch. In so doing, Congress perpetuated, rather than dismantled, the entrenched and fragmented structure of health administration and continued to rely heavily on state bureaucracies.

In this sense, the incremental way in which Congress legislates reinforces the centrality of state administration. Interestingly, the Chief Justice himself recognized this state-entrenchment point in his opinion, noting that "the States have developed intricate statutory and administrative regimes over the course of many decades to implement their objectives under existing Medicaid."<sup>45</sup> But the Chief Justice viewed that pattern as evidence only that states may become trapped in federal programs, rather than also as a potential tool through which states may preserve their centrality in and leverage over future federal legislation.

## 2. Incrementalism and State Experimentation

Federal policy incrementalism also finds its expression in policy *experimentalism*, and this is another way in which the states remain relevant to the development of federal statutory law. The notion that Congress lacks competence to address the complex social problems on its plate is commonplace, as is the notion that this complexity leads Congress to rely on expert federal agencies rather than drafting detailed legislative solutions. Less often acknowledged, however, is the way in which intrastatutory federalism serves a similar purpose. Part of what motivates legislative incrementalism is a lack of information about the "best" policy answer<sup>46</sup> and a related desire to test policies before expanding upon them. State administration of federal law is a modern-era twist on the historical concept

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visited Feb. 15, 2013) (citing Water Pollution Control Act, Pub. L. No. 80-845, 62 Stat. 1155 (1948)).

44. *NFIB*, 132 S. Ct. at 2639 n.23 (Ginsburg, J., concurring in part, concurring in judgment in part, and dissenting in part).

45. *Id.* at 2604.

46. See Allen Rostron, *Incrementalism, Comprehensive Rationality, and the Future of Gun Control*, 67 MD. L. REV. 511, 516 (2008).

of the “states as laboratories”<sup>47</sup> and allows for more policy experimentation than federal administration alone.

The ACA, for instance, has an extraordinary number of pilot projects written into the law.<sup>48</sup> These pilot projects are directed at policy questions for which Congress had no definitive answers (such as how to reduce costs without sacrificing quality of care). The ACA also evinces an explicit preference for *state* policy experimentation within the confines of the new federal law. Like countless other cooperative federalism programs, the ACA encourages states to experiment with how they choose to implement the new federal statute. In the context of the ACA’s insurance-exchange provisions alone, the statute mentions “state flexibility” six times<sup>49</sup> and explicitly contemplates that the exchanges will look different across the states. Like No Child Left Behind,<sup>50</sup> Medicaid,<sup>51</sup> the Clean Air Act,<sup>52</sup> and many other federal programs, the ACA also has a waiver provision that permits states, with permission, to substitute their own programs to accomplish the federal statute’s goal.<sup>53</sup>

As students of federalism well know, the states’ role as “laboratories” of experimentation is one of the most frequently touted benefits of state sovereignty.<sup>54</sup> But this mode of experimentation increasingly does not come from sovereignty-emphasizing federalism. Scholars have illustrated that states do not conduct experiments at the levels thought ideal by policymakers when states are left to their own devices.<sup>55</sup> The dearth of state-led policy experimentation is due to, among other things, the disincentives for a single state to bear all the costs of innovation and the risk that businesses will leave a state if it regulates in a more costly manner than others. Federal laws that allow for state experimentation provide an answer to this problem, and, ironically, such federal laws thereby help “federalism” realize its potential. Indeed, some of the most important state

47. See *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (“It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”).

48. See Vince Kuraitis, *Pilots, Demonstration & Innovation in the PPACA Health Reform Legislation*, E-CAREMANAGEMENT BLOG (Mar. 28, 2010), <http://e-caremanagement.com/pilots-demonstrations-innovation-in-the-ppaca-healthcare-reform-legislation>.

49. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1311, 1321, 1331, 1411, 1412, 124 Stat. 119, 186, 199, 231 (2010) (codified as amended in 42 U.S.C. §§ 18041, 18051, 18082 (Supp. V 2011)).

50. No Child Left Behind Act of 2001, Pub. L. No. 107-110, § 9401, 115 Stat. 1425, 1972–75 (2002) (codified at 20 U.S.C. § 7861 (2006)).

51. 42 U.S.C. § 1315 (2006).

52. *Id.* § 7543(b).

53. Patient Protection and Affordable Care Act § 1332 (codified at 42 U.S.C. § 18052 (Supp. V 2011)).

54. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

55. See Susan Rose-Ackerman, *Risk Taking and Reelection: Does Federalism Promote Innovation?*, 9 J. LEGAL STUD. 593, 594, 610–11 (1980); Edward L. Rubin & Malcolm Feeley, *Federalism: Some Notes on a National Neurosis*, 41 UCLA L. REV. 903, 925–26 (1994). See generally David A. Super, *Laboratories of Destitution: Democratic Experimentalism and the Failure of Antipoverty Law*, 157 U. PA. L. REV. 541 (2008).



policy experiments of the modern era have been conducted in the course of state administration of *federal* law.

There is a long history of federal law developing in reaction to and in dialogue with these state-led federal-policy experiments. In the environmental context, for instance, satisfactory levels of state innovation in the area of air-pollution control did not occur organically, even with the promise of federal funds, until Congress passed the major environmental statutes of the 1970s that effectively required the states to take the lead or have their air-quality laws preempted by federal statute. And in the Medicaid context, it was the states that first took advantage of that program's flexibility to expand the benefits-eligible population beyond the federal statute's initial target of children and their mothers. These state experiments, supported and incentivized by the federal government, formed the basis of Medicaid's subsequent national expansions to cover those same populations.

So, too, the philosophy behind the ACA's own Medicaid expansion—eligibility based on an income threshold rather than demographic categories—was first pioneered as a Medicaid state option by a few aggressive states. The Massachusetts health reform law<sup>56</sup>—the law on which much of the ACA was based—was itself made possible by a Medicaid waiver granted by the Bush Administration.<sup>57</sup> All of these are examples of experimentalism that derives from intrastatutory federalism, not from federalism in its traditional form.

#### IV. THE COURT'S OLD-FASHIONED FEDERALISM

The way in which federal policy incrementalism perpetuates a central role for the states has obvious salience for the Court's holding in the health reform case. A majority of Justices have now erected a barrier to that kind of legislative incrementalism—a barrier that may undermine the very state authority that the Court sought to advance. Seven Justices took the position that Congress does not have control over the amendment of its own federal programs when the states are its chosen administrative partners.<sup>58</sup> Instead, the Court held that those state partners are sometimes entitled to reject the statutory amendment and still remain part of the pre-amendment version of the program.<sup>59</sup> Applied to the ACA, the decision means that states are free to reject the ACA's expansion of Medicaid but may continue to participate in the pre-ACA version of Medicaid, even though that is a version that Congress abandoned when it passed the reform bill.

As a matter of structural formalism, there is something bizarre about this holding once one understands this modern federalism as a federalism that essentially is shaped by Congress. So understood, and as elaborated below,

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56. 2006 Mass. Acts ch. 58.

57. Ryan Lizza, *Romney's Dilemma*, NEW YORKER, June 6, 2011, at 38, 40.

58. *NFIB*, 132 S. Ct. 2566, 2607 (2012) (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.); *id.* at 2666–67 (joint dissent).

59. *Id.* at 2607–08 (majority opinion).

one might expect the Court to impose certain hurdles for the legislative process to clear if Congress wishes to utilize state partners. But there is something strange about the Court allowing the states effectively to create and participate in their own version of a federal program—by virtue of refusing to participate in Congress's amended version—when the states had no right to participate in the program in the first place.

On a practical level, moreover, the decision risks creating precisely the wrong kinds of legislative incentives from the standpoint of those who would further state power. To be sure, it is possible that the next time Congress wishes to accomplish an insurance expansion it will enlist the states' help relatively condition-free (for example, using the block grants popular with old-fashioned federalists). Or perhaps it will think twice about legislating at all. The Court itself has noted, in a 1986 case about the incremental expansion of Social Security benefits, that a "constitutional rule that would invalidate Congress's attempts to proceed cautiously in awarding increased benefits might deter Congress from making any increases at all."<sup>60</sup> These sorts of outcomes—namely, stymying legislation altogether or allowing the states to regulate with few federal strings—are likely the kinds of outcomes that the Court's federalists desire.

But it also is possible that, the next time, Court-watching statutory drafters will still decide to legislate and, to steer clear of the Court's new constitutional obstacle, will do so in a more nationalist manner. This would not be the federalists' desired result. It is true that the Medicaid challenge in the ACA case was brought by some states themselves, but half of the states argued the other side, and no modern federalism proponents today are advocating nationalizing Medicaid. Such an idea (an effective "Medicare for all") has been anathema to federalists at least since Ronald Reagan famously associated that possibility with "socialized medicine."<sup>61</sup>

In fact, it was federalism proponents who supported the creation of the state-led Medicaid program in the first place, as part of the Social Security Act's 1965 legislative compromise, just as it was the more traditionally federalist house of Congress, the Senate, that insisted that the ACA's insurance exchanges be operated by the states instead of the federal government. It is also no coincidence that, now that the Court has upheld the rest of the ACA, some policymakers are invoking "federalism" to try to convince states to establish their own health insurance exchanges under the Act rather than letting the federal government operate the exchanges for them. As one governor put it: "[A] federally facilitated exchange is not the ideal approach. Regulating the insurance market is a power best left in the hands of the states."<sup>62</sup> A well-known conservative economist has argued

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60. *Bowen v. Owens*, 476 U.S. 340, 348 (1986).

61. *Ronald Reagan Speaks Out Against Socialized Medicine*, YOUTUBE (Aug. 1, 2007), <http://www.youtube.com/watch?v=fRdLpem-AAAs> (audio of 1961 LP of the same name).

62. Elizabeth Crisp, *Federal Government Will Start Setting Up Missouri's Health Exchange*, ST. LOUIS TODAY (Nov. 12, 2012), <http://www.stltoday.com/news/local/govt-and->

that allowing the federal government to operate the state exchanges would open the door to a nationally run health care program.<sup>63</sup> Of course, now that the ACA has been upheld, as a formal (constitutional) matter, the federal government is regulating the insurance market regardless. But as these comments reveal, in today's world, both as a practical matter and also as a matter of how a program is understood and experienced, which level of government is doing the implementing of federal law is, indeed, a question about federalism.

The Court's decision also may unproductively incentivize comprehensive, rather than incremental, lawmaking. This is because the decision effectively tells Congress that it may not be able to amend federal programs later if Congress still wishes to use state administrators. Putting aside the political impossibility of such comprehensive lawmaking on a routine basis, it also seems remarkably unwise given the complexity of modern legislative problems. One benefit of incrementalism is its reversibility. State-led federal policy incrementalism, moreover, is particularly reversible because the experimentation often occurs on a smaller scale.<sup>64</sup>

It is something of a mystery why a Supreme Court so concerned with the expansion of federal power would obstruct gradual, state-led federal policy development in this manner. The most plausible explanation is that the Court wished to turn back the tide of major federal legislation altogether; or perhaps the Court simply took particular offense at the policy choices in this statute. As noted, the Chief Justice's opinion and the joint dissent are laced with distaste for the social solidarity model that the ACA embraces, and both condemned the Medicaid expansion for its role in this effort. But even those Justices acknowledged that the days of only minor federal-law intrusions into daily American life have long since passed.

#### *A. Nationalism or State Leverage?*

Let us now examine the other side of this coin. State administration of federal law does not always work to empower the states. Instead, state administration may offer the federal government a subtle path toward encroachment on state terrain.<sup>65</sup> Relatedly, it may be a way for Congress to obscure its political accountability for particularly unpopular decisions. In such contexts, intrastatutory federalism may have a nationalizing, not federalizing, effect.

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politics/political-fix/federal-government-will-start-setting-up-missouri-s-health-exchange/article\_4bee6ae8-6b8d-5c6c-9ecf-e90dd36234b6.html (statement of Gov. Jay Nixon).

63. See Douglas Holtz-Eakin, *Yes to State Exchanges*, NAT'L REV. ONLINE (Dec. 6, 2012, 12:00 PM), <http://www.nationalreview.com/articles/334956/yes-state-exchanges-douglas-holtz-eakin>.

64. ROBERT A. DAHL & CHARLES E. LINDBLOM, *POLITICS, ECONOMICS, & WELFARE* 83 (1953).

65. For elaboration of these arguments, see generally Gluck, *supra* note 14.

The seven Justices who voted to strike down the Medicaid expansion focused especially on these arguments about accountability, encroachment, and the diminishment of independent state power. But their specific arguments seemed ill tailored to the matters at hand. The Justices' focus on accountability, for example, translates badly to the doctrinal test that they articulated, which effectively allows Congress to engage in small-scale—and therefore less visible—expansions of cooperative federalist programs but holds that larger changes raise constitutional concerns. If anything, the public is more likely to know where to place blame for major, not minor, changes.

With respect to traditional state functions, the joint dissent emphasized that allowing the Medicaid expansion “would permit Congress to dictate policy in areas traditionally governed primarily at the state or local level.”<sup>66</sup> This concern, however, ignores the fact that Congress can use its broad power to tax and spend for the general welfare<sup>67</sup> in areas of traditional state control regardless of whether the states are co-implementers. Medicare is precisely such an effort.

And with respect to the balance of powers, the Chief Justice emphasized the “independent power of the States . . . as a check on the power of the Federal Government.”<sup>68</sup> But the Court seemed wrong to invoke state “independence” as a real-world limitation on federal authority. Once one accepts, as the Court did, that Congress has extremely broad power to regulate by itself (if it is willing to use the taxing power), the best chance that the states have to limit or shape the federalization of government functions is via their representation in Congress and through their role as implementers of federal law. States must protect their power *through* the national political process, rather than by offering an alternative to it. If anything, the famous “political safeguards of federalism”<sup>69</sup> have special salience here.

The joint dissent did recognize that Congress has become dependent on state implementation.<sup>70</sup> Although the Justices did not see political leverage in that dependence, others have. Numerous scholars have described how the states exert formidable political power over the shape of the federal laws they are designated to implement.<sup>71</sup> It was no coincidence that the National Governors Association and the National Association of [State] Insurance

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66. *NFIB*, 132 S. Ct. 2566, 2662 (2012) (joint dissent).

67. U.S. CONST. art. I, § 8, cl. 1.

68. *NFIB*, 132 S. Ct. at 2578.

69. See Herbert Wechsler, *The Political Safeguards of Federalism: The Role of the States in the Composition and Selection of the National Government*, 54 COLUM. L. REV. 543, 544 (1954).

70. *NFIB*, 132 S. Ct. at 2657–58.

71. See, e.g., JOHN NUGENT, SAFEGUARDING FEDERALISM: HOW STATES PROTECT THEIR INTERESTS IN NATIONAL POLICYMAKING 201 (2009); Kramer, *supra* note 1, at 283 (“Because the federal government depends on state administrators to oversee or implement so many of its programs, states have been able to use their position in the administrative system to protect state institutional interests in Congress.”); cf. Ruger, *supra* note 16.

Commissioners were active political operators as the ACA was developed and that their efforts had a real effect on how the statute was drafted.

A separate and much more difficult question is who “speaks” for the states in the political process (votes in the Senate? The National Governors Association? Amicus Brief sign-ons? etc.) or whether it even makes sense to think of “the states” as a single unit, with unified interests, when in fact states often take different sides on federalism-related questions (here, too, the ACA is no exception).<sup>72</sup> Some states also may have disproportionate power relative to others.<sup>73</sup> As one particularly famous example of the difficulty of evaluating the question of whether any specific federal statute is state protective, recall the high-profile federalism case *New York v. United States*, in which the Court invalidated as violative of federalism a federal statutory scheme that was constructed by a coalition of state governors, speaking for the majority of the National Governors Association, as an effort to preserve state power.<sup>74</sup>

These difficulties, however, are not a reason for the Court to incentivize Congress to leave the states out of its legislative schemes. Instead, they are difficulties related to how legal doctrines should be constructed. They reveal the kinds of questions attendant to understanding and evaluating modern federal-state relations, and the Court’s opinion in the ACA case offers no roadmap for answering them.

The Chief Justice likewise missed the most important point when he disputed Justice Ginsburg’s contention that the extent of Congress’s constitutional power to expand Medicaid is proven by the fact that Congress could replace the statute altogether.<sup>75</sup> The Chief Justice wrote that “[p]ractical constraints would plainly inhibit, if not preclude, the Federal Government from repealing the existing program and putting every feature

72. Thanks to Judith Resnik for a clarifying conversation on this point.

73. Lynn A. Baker, *Putting the Safeguards Back into the Political Safeguards of Federalism*, 46 VILL. L. REV. 951, 966 (2001) (arguing that the structure of the Senate “ensures small population states a disproportionately large slice, and large population states a disproportionately small slice, of the federal fiscal and regulatory ‘pie’” and so “obviously infringes on the autonomy of the states that are burdened by, rather than beneficiaries of, this redistribution.”).

74. See Brief for the Respondent, *New York v. United States*, 505 U.S. 144 (1992) (Nos. 91-543, 91-558, 91-563), 1992 WL 526126, at \*4-5 (“A task force headed by seven Governors, working under the auspices of the National Governors’ Association (NGA), proposed a ‘state solution’ to the [low-level radioactive waste] disposal problem, which the NGA then presented to Congress with the unanimous support of its members.”); see also *New York v. United States*, 505 U.S. 144, 150-51 (1992) (“Relying largely on a report submitted by the National Governors’ Association, . . . Congress declared a federal policy of holding each State ‘responsible for providing for the availability of capacity either within or outside the State for the disposal of low-level radioactive waste generated within its borders’ . . . .” (citations omitted)). Ironically, even *New York* supported the legislation. See Judith Resnik, Joshua Civil & Joseph Frueh, *Ratifying Kyoto at the Local Level: Sovereignism, Federalism, and Translocal Organizations of Government Actors (TOGAS)*, 50 ARIZ. L. REV. 709, 749-51, (2008).

75. *NFIB*, 132 S. Ct. at 2629 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

of Medicaid on the table for political reconsideration.”<sup>76</sup> But what are those “practical constraints” if not the same informal, political—and not constitutional—federalism constraints of the sort that this Essay has emphasized? State opposition to a wholesale elimination of Medicaid would be fierce. Such a move, if the federal government then nationalized the program, also would be perceived as a massive federal-government takeover, even though as a formal matter it would be no different, since Medicaid is a federal program in the first place. The predicted political upheaval is what makes the repeal of Medicaid a practical (but not constitutional) impossibility. This is modern federalism at work.

Indeed, the very fact that each of the opinions in the case is full of such “practical” arguments illustrates that we are talking about something other than sovereignty-based federalism. (For another example, consider the dissent’s listing of the “practical reasons” preventing the states from declining Medicaid funds, including the political difficulty of levying state taxes to replace the lost federal money.<sup>77</sup>) As proof positive, the Court could not, and in fact explicitly refused to, draw a doctrinal line to demarcate the point at which congressional expansions of state-administered federal programs become coercive. Instead, the Court articulated a virtually unadministrable rule that recognizes the power of the federal government to amend its state-led programs as it wishes so long as the amendments are not too “dramati[c].”<sup>78</sup> The “we-know-it-when-we-see-it” quality of this doctrine does not fit well with a theory of federalism that depends on hard boundaries.

## V. FEDERALISM AS A DOCTRINE OF STATUTORY INTERPRETATION

This Essay has focused on the unrealistic assumptions about federalism that underlie the Court’s opinion. How legal doctrine might evolve to effectuate the different vision of federalism that I have offered requires many more pages and much deeper consideration. But I wish to conclude with one particular point about the direction that such doctrine might take, and that is to emphasize that statutory, not constitutional, doctrines seem a better fit for this context.

The Court has recognized this before: it has created a multitude of statutory interpretation doctrines in the name of “federalism” that are not really about the traditional, hard-boundary federalism that the health care decision tried to resurrect. To take just one of many possible examples, the presumption against preemption is a frequently employed rule of statutory interpretation that requires Congress to be clear when it wishes to legislate over (i.e., preempt) existing state law. The presumption is employed when Congress unquestionably has the authority to preempt and so is not about any constitutional boundary. It is, rather, a statutory interpretation doctrine

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76. *Id.* at 2606 n.14 (majority opinion).

77. *Id.* at 2657 (joint dissent).

78. *Id.* at 2606.

that acknowledges Congress's discretion to move the line of state-federal regulatory authority, but demands a more public, accountable, and deliberative federal political process—by requiring Congress to be particularly explicit—when it does so.

The Court has devised similar rules that require Congress to speak extra clearly when it legislates in areas of traditional state authority or wishes to abrogate state sovereign immunity. It is no fluke that each of these doctrines emerged within the last century. Unlike many other American statutory interpretation rules, which have traditions going back to old English practice, these doctrines are the interpretive rules of the modern regulatory state. They are a direct judicial response to the way that the New Deal changed how federalism works.

The doctrine at issue in health reform's Medicaid expansion was precisely one of these informal, federalism-protective rules of statutory interpretation. The so-called *Pennhurst* rule<sup>79</sup> requires Congress to speak clearly when it attaches strings to grants of federal money to the states. Though most often taught in constitutional-law courses, *Pennhurst* is also a statutory-interpretation doctrine. At bottom, the rule is about Congress's intentions and the clarity with which Congress speaks, not about the limits of Congress's authority. *Pennhurst* tells us that Congress has the discretion to attach whatever (legal) conditions it likes to its statutes, as long as it makes those conditions clear.

The Court applied the *Pennhurst* rule in the ACA case but did not truly follow it. The Court recognized that Congress included the clear statement that *Pennhurst* requires: the Medicaid statute expressly reserves to Congress the "right to alter, amend, or repeal any provision" of the statute.<sup>80</sup> But the Court layered on top of that rule its muddy, "some-changes-are-too-much-regardless-of-the-warning" doctrine that now makes it impossible for Congress to predict when it will be invoked.

One explanation for the cloudiness of the ACA's new rule may be the Court's reluctance to go further down the road of acknowledging federalism as a creature of Congress's creation. *Pennhurst* suggested that the threat to state sovereignty is eliminated when Congress makes its intentions plain. Perhaps the Court was no longer content to rest with that rule because the Court realized that the *Pennhurst* doctrine is much more about federal statutory design than about state sovereignty in the first place.

Indeed, the entire ACA opinion contains this tension. The Court moved uneasily between recognizing Congress's broad power to legislate and attempting to protect the historical limits on that power. Consider, for example, how this tension between modern statutory power and traditional constitutional restraints is evident in the Court's decision on the insurance-purchase-mandate question. There, the Court claimed to apply a rule of *statutory interpretation*, the so-called doctrine of constitutional avoidance,

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79. See *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U. S. 1, 17 (1981).

80. 42 U.S.C. § 1304 (2006).

to save the mandate from unconstitutionality by “interpreting” it as a tax.<sup>81</sup> The Court then walked an awkward line by holding that Congress has the power to control the labels that it uses for some purposes, but not for others.<sup>82</sup> Throughout, the Chief Justice invoked the importance of state sovereignty six times.<sup>83</sup>

It is constitutional heresy to suggest that the concept of state sovereignty might be a poor fit, even when we are talking about a federal legislative landscape in which the states play a role only at Congress’s discretion. But to press the point, the states are not the only implementers of federal statutes. Congress also routinely relies on nonprofits, quasi-governmental associations and for-profit entities to implement federal law. No one contends that those players are sovereigns in any sense, even though their role in federal statutory implementation is often quite similar to that of the states.

None of this is to say that the states are not important players in our government structure or that sovereignty is not a relevant concept to describe many other aspects of the states’ existence (such as their control of their own government structures). This is an argument about how, realistically, state policymaking can remain productive and relevant within the ever-expanding landscape of federal lawmaking.

Of course, not everyone agrees that states should be aggressive national policymakers in the first place, and each context is unique. But even those who generally resist federalism might focus closer attention on state implementation of federal law and, in particular, on the parallels between state and private implementation noted above. If one alternative to state-led federal statutory schemes is a bigger federal government, another alternative is more privatization of what previously had been government work. Many scholars have raised accountability, transparency, and democracy concerns associated with this trend toward privatization. One might consider whether state implementation is preferable to privatization; indeed, whether state implementation is a buffer to the withdrawal of government altogether.<sup>84</sup> So understood, state implementation of federal law is a phenomenon that both nationalists and federalists may have interest in preserving.

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81. See *NFIB*, 132 S. Ct. at 2600–01. In my view, however, the Court did not apply the doctrine properly. The doctrine is best understood as an aid in the interpretation of ambiguous statutory language, not as an aid in choosing among several constitutional hooks for text whose meaning is clear.

82. See *id.* Specifically, the Court held that it would respect Congress’s decision to call the “tax” a “penalty” for purposes of whether the Anti-Injunction Act’s prohibition on pre-enforcement challenges applied, but that it would decide for itself whether the mandate was a “tax” for purposes of Congress’s power to enact it in the first place.

83. See *id.* at 2578, 2602–03.

84. See Judith Resnik, *Globalization(s), Privatization(s), Constitutionalizations, and Statization: Icons and Experiences of Sovereignty in the 21st century*, 11 INT’L J. CONST. L. 162 (2013).



Consider in this light, then, some statutory-law alternatives to sovereignty-focused constitutional-law doctrine. I have argued previously that one of the most important, but often ignored, federalism relationships on the ground is the *intergovernmental administrative* relationship; the relative power of federal administrators over the state administrators concurrently entrusted with implementing federal laws.<sup>85</sup> The Constitution has nothing explicit to tell us about how tightly federal agencies can tie their state partners' hands when Congress asks both federal and state administrators to co-regulate. But statutory interpretation doctrine might. We already have statutory interpretation rules that give federal agencies leeway to implement federal laws, and similar rules could be developed that give such deference to state implementers or that even change the balance of power at times between federal and state agencies. My own recent empirical work suggests the possibility that Congress sometimes does intend to give state implementers more policy-implementation discretion than that for which current doctrine allows.<sup>86</sup>

In fact, the ambiguities currently attendant to these interagency relationships are precisely what have been cited in the health reform context as the reason for some states' resistance to operate their own insurance exchanges. States claim that they do not have enough information about how much discretion they will have to implement the statute themselves or what rules the Department of Health and Human Services will impose on them.<sup>87</sup> States have voiced similar concerns with respect to other parts of the statute.<sup>88</sup> None of these concerns stems from arguments about constitutional boundaries—that is, about the federal government's power to impose certain rules on state administration. Rather, these are arguments about how state implementation will be *operationalized* and the respective powers of state and federal agencies, all within statutes that everyone agrees Congress has legitimately enacted. Current legal doctrine does not assist in regulating these relationships.

In a similar vein, Professor Erin Ryan has argued that legal doctrine should oversee the fairness of the political bargaining process—the behind-the-scenes negotiations between state and federal actors—and not the contours of the ultimate result.<sup>89</sup> The Court-created federalism “clear-statement rules” already in play and discussed above are of the same order: those rules do not prohibit any particular policy outcome. Rather, they are an effort to *shape the legislative process*, and to give additional leverage to

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85. See Gluck, *supra* note 14.

86. See Abbe R. Gluck & Lisa Schultz Bressman, *Statutory Interpretation from the Inside—An Empirical Study of Congressional Drafting, Delegation and the Canons: Part I*, 65 STAN. L. REV. (forthcoming 2013) (manuscript on file with author).

87. See, e.g., Jason Millman, *Chris Christie Nixes State-Run Insurance Exchange*, POLITICO (Dec. 7, 2012, 5:03 AM), <http://www.politico.com/story/2012/12/christie-nixes-state-run-insurance-exchange-84718.html>.

88. See Gluck, *supra* note 14, at 578–79.

89. Erin Ryan, *Federalism and the Tug of War Within: Seeking Checks and Balance in the Interjurisdictional Gray Area*, 66 MD. L. REV. 503, 650–65 (2007).

federalist voices in how statutes are designed.<sup>90</sup> Those who have raised concerns about asymmetries across the horizontal-federalism landscape might similarly think more about how the statutory design process might be restructured to better equalize power across states.

Admittedly, each of these paths may plunge courts precisely into the kind of political terrain that courts generally eschew. But that discomfort—and the recognition that the political arena is where these boundaries increasingly must be worked out—would seem a reason for courts further to limit their intervention in Congress's statutory work, and not a reason for courts to rely on antiquated constitutional doctrine to provide them with a more familiar, even if inapposite, path to decision.

It also is exceedingly difficult to determine when a particular federal statutory structure is in the "state interest," not only because the states are not always a cohesive unit, but also because what the metric might be is not clear. Federalism is associated with many different kinds of benefits, and different federal statutes generate different packages of those benefits. Some statutes, for example, may encourage more local participation but less experimentation, while others do the opposite. Who is to say which statute is "sufficiently" federalist? In the health reform context, for example, we do not yet have enough information to evaluate the question of how state-protective the health-insurance exchange provisions ultimately will be. What we can say, however, is that thanks to the ACA's intrastatutory federalism, Massachusetts now is operating an insurance exchange through which it can police and exclude insurance plans offered, while Utah simultaneously has chosen to operate an open-market model exchange in which all insurers are welcome. That diversity and deference to local governmental preferences likely would not have been possible in a single federal model. There is something that rings of federalism here, but is it "enough" (and enough for what)? Ultimately, our modern federalism may best be understood as existing on a continuum rather than as a feature that is either present or absent from a regulatory scheme.

One final point: if federalism doctrine ultimately does move toward rules aimed at how Congress drafts statutes rather than constitutional rules that police outcomes, it will be incumbent upon the Court to adhere to the statutory rules that it announces. One of the most important, and unanswered, questions for modern statutory law is the extent to which Congress and the Court are in dialogue over statutory interpretation; that is, the extent to which Congress legislates in the shadow of the Court's interpretive doctrines and the extent to which the Court, in turn, respects Congress's intentions.<sup>91</sup> Any set of legal rules that aims to make Congress speak more clearly must be heard and employed by legislative drafters. In

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90. See also Andrzej Rapaczynski, *From Sovereignty to Process, the Jurisprudence of Federalism After Garcia*, 1985 SUP. CT. REV. 341, 418–19 (suggesting that clear statement rules might be ways for judges to adopt a more deferential stance to Congress while still safeguarding federalism).

91. See Gluck & Bressman, *supra* note 86.

the context of the Medicaid expansion, the Court damaged its own credibility as a reliable partner in that dialectical relationship by saying “not good enough” when Congress employed precisely the kind of disclaimer for which the Court previously had asked.

#### CONCLUSION

Traditional federalists embrace state power in the absence, or instead, of federal authority. And they view autonomy as the ballgame. It is this traditional federalism that the Court wished to resuscitate in the ACA litigation. But that option was never on the political table when it came to designing the health reform statute. The congressional majority that passed the ACA was convinced that national legislation was necessary. And so Congress proceeded as it typically does, changing national policy by building on already-existing federal laws that themselves were the result of incremental federal legislation over a backdrop of historical state control. The outcome was major federal legislation that, instead of marginalizing the states, kept them front and center. The Court misread the ACA as a statute that is fundamentally anti-state, when in fact it is state empowering in many respects. The ACA creates precisely the kinds of partnerships that maintain the states’ relevance in the modern statutory era, and the federalists may wish to think twice before again discouraging them.

## *Notes & Observations*